COGNITIVE PATIENT LABEL

DATE:

MRN:

NAME

Date of Birth:

PATIENT REQUEST TO RESTRICT DISCLOSURE OF INFORMATION

As a patient, you have the right to request that Henry Ford Health System (HFHS) restrict the use or disclosure of your patient information. The purpose of this form is to allow you to request a restriction.

If your request is approved, the restriction will be effective from the date of the written confirmation from HFHS. In certain circumstances, HFHS may deny your request. If your request is denied, you will receive notification of the denial in writing. Restriction agreements may not apply when there is a need to provide treatment in emergency situations.

When completed, please return this form using your choice of the following:

- Mail to: Henry Ford Health System, Information Privacy & Security Office, One Ford Place Detroit, MI 48202
- Fax: (313) 874-9449
- Email: IPSO@hfhs.org (If you choose to email this form, please be aware that email is not encrypted/secure and your information could be viewed while in transit.)

This form **must** be signed and dated. Incomplete forms will be returned to you unprocessed. If you choose to cancel your restriction, you must do so in writing by contacting the Information Privacy & Security Office using the contact information above.

PATIENT / REQUESTOR INFORMATION

If the requestor is the personal representative, please attach certifying documentation of your status as the personal representative, such as a Durable Medical Power of Attorney or Guardianship papers.

Patient:_____
(Name of Patient) Medical Record Number Date of Birth

Requested by (if other than patient): _____ _____
(Personal Representative of Patient) (Relationship to Patient)

Patient/Requestor Contact Information: _____ _____
(Street Address) (City/State/Zip) (Telephone)

Patient/Requestor Signature:_____Date: _____Time: _____

RESTRICTION REQUEST SECTION A - RESTRICT DISCLOSURES TO FAMILY, FRIENDS AND/OR CAREGIVERS:

Unless you object in writing, we may disclose your patient information to a friend, family member or other caregiver who is involved in your medical care or who helps pay for your care. We may also tell your family or friends about your location of care and general condition or death. We may disclose your patient information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you are unable or unavailable to opt in or out of these disclosures, we will use our best judgment in communicating with your family and others.

☐ I request that my patient information **not** be disclosed to any family, friends or caregivers involved in my care or who help pay for my care.

☐ I request that my Patient Information **not** be disclosed to the specific family, caregivers or friends(s) named below:

_____

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☐ I request that my patient information **not** be disclosed to any entity assisting in disaster reliefs efforts that would notify my family about my condition, status and location in the event of a disaster.

RESTRICTION REQUEST SECTION B – RESTRICT OTHER DISCLOSURES

☐ Do not share my information for treatment purposes.

☐ Do not share my information for payment purposes.

☐ Do not share my information for the healthcare operations of Henry Ford Health System.

☐ Do not submit my patient information to my insurance company, I am a self-pay patient. *(Payment in full must be received at time of service).*

☐ Restrict access to my Patient Information from the following HFHS Employee; Department; Committee or Board:

_____

☐ Restrict access or disclosure of my Patient Information to the following company (Business Associate) of Henry Ford Health System.

_____

☐ Place the following password/PIN on my Medical Record account (used for verification of identity purposes)

Provide a 4 digit PIN _____

FOR HFHS USE ONLY

For IPSO Use Only

Date Received:_____Date forwarded to Medical Records**:** _____

Received By: _____
(Initials)

☐ Request Approved

☐ Request Denied

Approval/ Denial Letter Sent Date: _____

For HIM Use Only

Date scanned/Inserted into medical record or file: _____